Academy of Vision and Learning, Optometric Vision Therapy
Qiaoqiao Wang O.D., Ph.D

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone number: _____

INFORMATION TO BE DISCLOSURED:

Information covered by this authorization includes vision exam records and reports.

PERSONS AUTHORIZED TO USE OR DISCLOSE INFORMAITON:

Information listed above will be used by or disclosed by

_____

TO WHOM INFORMATION MAY BE DISCLOSED:

Information described above may be disclosed to:

Qiaoqiao Wang O.D., Ph.D

Academy of Vision and Learning, Optometry

2514 Boston Post Road, Suite 1C, Guilford, CT 06437

Fax 203 738-0523

EXPERIATION OF AUTHORIZATION:

This authorization is effective through _____unless revoked or terminated by the patient or patient's personal representative.

I AUTHORIZAT THE RELEASE OF MY HEALTH IFORMATION UNDER THE ABOVE TERMS AND CONDITIONS. I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

DATED_____ PATIENT SIGNATURE_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

RELATIONSHIP TO PATIENT_____PRINT NAME_____